Dental Care
DR. LINDSAY TUCKWOOD

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Authorization to Release Records and X-rays

Each Adult Patient over 18 years of age must sign his/her own Authorization to Release form.

Date: YYYY/MM/DD

Dear Dr.:_____________________ (name of dental office and city: ______________________________)

I,______________________________________ would like to thank you for the dental care you have provided and ask, in order to preserve continuity of care, to have any clinical records and current radiographs for myself and the following family members sent to Dr. Lindsay Tuckwood.

Patient's Name(s):

____ ____

____ ____

Patient Signature: ____

_ _

Please submit the following information and latest x-rays to provide a smooth transition for the patient(s) listed above:

Date of latest 01103: ____

Date of last recall: ____

Date and copy of last BW's: ____

Date and copy of last Pan or FMS: ____

Copy of periodontal charting

List of outstanding treatment:____

Any other information relevant to the continuation of care: _____________________________________

Thank you!